Revised 02-01-01

SICK LEAVE DONATION FORM

Name of Donor:_____

Department:_____

Social Security Number:_____

Amount of Donation to be credited to Recipient: _____
(Employee must have 75 hours remaining after donation. Minimum amount employee may donate is 7.5 hours.)

Name of Recipient:_____

Department: _____

Social Security Number:_____

I hereby certify that this donation is given without expectation or promise for any purpose other than that authorized by KRS 18A.197.

_____

Signature of Donor **Date**

This is to certify that the employee named above has a sufficient sick leave balance to donate the hours indicated under the provisions of KRS 18A.197.

_____

Signature of Appointing Authority **Date**

The Donor's Payroll Officer must forward one copy of this form to the Recipient's Payroll Officer and one copy to the Personnel Cabinet, Processing & Records Branch, Room 531, 5th Floor, 200 Fair Oaks Lane, Frankfort, Kentucky 40601.

TO BE COMPLETED BY DONOR'S PAYROLL OFFICER UPON RECEIPT

Company Number: _____ Department Name: _____

_____ Date _____

PAYROLL OFFICER

TO BE COMPLETED BY RECIPIENT'S PAYROLL OFFICER

Recipient's current sick leave balance: _____ + _____donation = **_____ Recipient's New Sick Leave Balance**

Company Number: _____ Department Name: _____

_____ Date _____

PAYROLL OFFICER